State of Rhode Island
Department of Administration / Division of Purchases
One Capitol Hill, Providence, Rhode Island 02908-5855
Tel: (401) 574-8100 Fax: (401) 574-8387

Solicitation Information
March 29, 2013

ADDENDUM # 2

LOI #7461245
LOI Title: Medicaid Integrated Care Initiative for the Rhody Health Option Program

Bid Opening Date & Time: Tuesday, April 9, 2013 @ 11:15 AM (EST)

Notice to Vendors:

ATTACHED ARE VENDOR QUESTIONS WITH STATE RESPONSES.

NO FURTHER QUESTIONS WILL BE ANSWERED.

David J. Francis
Interdepartmental Project Manager

Interested parties should monitor this website, on a regular basis, for any additional information that may be posted.

Vendor Questions for LOI # 7461245 Medicaid Integrated Care Initiative for the Rhody Health Option Program

Question 1: **In Phase I, will RHO participants receive full range of benefits from the RHO health plan? Can the State list the set of services provided by the RHO health plan? (LOI-page 22-23-Section 2.5 Pathway #2: Health Plan Model – Phase I)**

Answer to question 1:

The in-plan services are contained in Attachment A of the Model Contract (also Appendix C of this procurement). These benefits are Medicaid-covered services. For non-duals, all Medicaid covered services listed in Attachment A of Appendix C are the covered benefits to be offered by the RHO Health Plan. For Medicare and Medicaid eligible (MME) members, the RHO health plan will reimburse the Medicaid obligation of a Medicare claim, or will reimburse for Medicare covered services once the Medicare benefit has been exhausted, in addition to the services that Medicare denies as non-covered. These are called crossover claims. Currently, the state's fiscal agent processes crossover claims using a "lesser of logic". This means that when Medicare has paid as primary, the claim "crosses over" to Medicaid for additional payment. The claim adjudicates and is paid at the "lessor of" the" Medicaid allowable – the Medicare payment" or the "co-insurance and /or deductible." If Medicare paid more than the Medicaid allowed amount, the claim will be paid at zero. If the Medicaid fee-schedule is greater than Medicare paid amount, a payment is made to the provider utilizing the above mentioned "lessor of" logic. Similarly, if Medicare denies a claim as either non-covered or as exceeding the benefit limit, the claim is submitted to Medicaid by the provider for payment. The provider must include a copy of the Medicare explanation of benefits with the claim. Medicaid will adjudicate the claim against the current fee schedule for Medicaid covered benefits. The current adjudication of institutional claims pays the co-insurance and/or deductible, multiplied by the providers RCC%.

All of these crossover payments were part of the historical fee-for-service utilization data used for setting capitation rates.

Other that the patient share for certain individuals who receive LTSS, there are no out-of-pocket costs for Rhody Health Options members.

Question 2: **When does the state plan to release fully loaded Medicaid/Medicare capitation rates for Phase II? (LOI-page 23-Section 2.5- Phase II)**

Answer to question 2:

The state's intent is to enter into a three-way with CMS and health plans to administer all Medicare and Medicaid covered services. The first step in this agreement is a signed Memorandum of Understanding (MOU) between CMS and the state. Rhode Island does not have a signed MOU with CMS. Therefore, the state does not have an estimated date for release of fully loaded Medicaid/Medicare capitation rates. In Phase II, CMS will set the Medicare portion of the rate, as well as the Part D portion, and the state will set the Medicaid portion.

Question 3: **Please clarify the expectation of the health plans for this population for Phase I and Phase II ? (LOI – page 24- Section-2.5)**

Answer to question 3:

The state is unclear which population this question refers to, but has assumed the question refers to clients with Severe and Persistent Mental Illness (SPMI) and clients with Developmental Disabilities (DD) in its response.

Question 4: **Does this mean either: 1) that Health Plans selected to participate in the ICI will be responsible for both the delivery and payment of these Medicaid services in Phase I; or 2) that selected Health Plans will be responsible only for coordinating these services, which will be reimbursed under the current system? In either case, what number of individuals does the State anticipate will be enrolled in selected Health Plans on a monthly basis during Phase I? Additionally, will the estimated 4,031 MMEs (SFY2011) currently enrolled in Medicare Advantage plans be excluded from these arrangements? (LOI – page 25- Section 2.6)**

Answer to question 4:

During Phase I, the expectation of the RHO health plan for members with SPMI and DD is to provide covered services listed in Attachment A of Appendix C, and to coordinate with the services listed in Attachment B of Appendix C. During Phase II, EOHHS intends that those specialized services funded and managed by BHDDH (as listed in Attachment B of Appendix C) for individuals with SPMI and developmental disabilities may become in-plan services as designed by new State requirements. EOHHS and BHDDH will establish program performance requirements and capabilities that will serve as the basis for managing these programs. This work will take place in the next few months and is targeted to be completed by July 2013. The relationship between the Health Plans selected for participation in Phase I and the design of specialized services for Phase II into an integrated system will be specified in the July 2013 requirements.

The estimated enrollment for the four-month phased enrollment is listed on page 26 in Section 2.6. Medicare Advantage enrollees will not be excluded from enrollment in Phase I. Once the initial four-month enrollment phasing is complete, newly eligible Medicaid-only or MMEs will be auto-assigned on an equal and random basis to a participating Rhody Health Options health plan. The estimated number of new enrollees per month is represented in the table found in the response to Question #5. It is important to note that the table depicts overall enrollment to remain flat, with approximately the same new enrollees each month as there are enrollees leaving the program.

Question 5: **How many Rhody Health Option eligible persons are currently enrolled in a Medicaid health plan and how many will go through the voluntary selection process? How will the state auto enroll duals not currently receiving Medicaid services? (LOI-page 25 –Section 2.6 Enrollment Approach and Model Contract – page 18- Section 2.04.07 Rhody Health Options (RHO) Non-Biased Enrollment Counseling)**

Answer to question 5:

The state is seeking authority to mandate enrollment into either Rhody Health Options or Connect Care Choice *Community Partners*. There are approximately 600 LTSS clients currently enrolled in Rhody Health Partners who will transition to Rhody Health Options. All remaining eligible members will receive an enrollment letter with an auto-assignment to a delivery system and/or health plan – approximately 24,000 clients. The auto-assignment will occur as described in Section 2.6 of the LOI on page 26. Once this initial enrollment phase is complete, newly eligible clients will be auto-assigned to a participating Rhody Health Options health plan. These clients will have a choice to switch health plans, or choose Connect Care Choice *Community Partners*. The table below provides estimates for ongoing monthly enrollment. Overall enrollment remains flat, with approximately the same new enrollees each month as there are enrollees leaving the program.

Full Dual Monthly Turnover Stats in 2012 August to December

	Aug.	Sep.	Oct.	Nov.	Dec.
New in current month	826	807	773	818	694
Drop from last month	767	799	864	717	687
Current month total	29639	29647	29556	29657	29664

Note:

This table captures the difference between snapshot stats on the 1st of every month
This includes anyone in Medicaid with Medicare Part A and B, or with Medicare Part C
QMB, SLMB, and QI are excluded

Bidders should refer to Appendix A, The Integrated Care Initiative data book, Tables 2.3.1 and 2.3.2 for average eligible members and unique eligible members. The tables below also offer additional information regarding transition and migration patterns of clients who need long-term services and supports (LTSS).

Of those who were community living, not medically needy, how many of them progress to Waiver or LTC?					
Based on Unique Not Medically Needy Users, How many who are in the Community Living group in 2008					
				3 yrs 2008/2011	1 yr 2009/2010
	a) Are still Medicaid eligible in 2011			75.0%	87.8%
	a) Move to waiver from period 2008 to 2011			6.0%	1.5%
	b) Move to LTC from period 2008 to 2011			3.3%	2.2%
			TOTAL	9.3%	3.7%

	Unique Users			
LTC		351	433	515
MRDD		22	34	54
Waiver		237	800	949
SPMI		239	279	330
MedNeedy	79	84	110	121
NotMedNeedy	15762	12908	11026	9907
Total	15841	13841	12682	11876

From 2010 TO 2011 3.8% of persons in the waiver group moved to the LTC group. Over 3 years, 14.4% moved to LTC.

What happens to people who are receiving HBCS?							
Of those duals receiving HCBS services in 2008, how many of them:					2008/2011		
	a) Remain eligible for Medicaid over three years?				67%		
	a) Persist in HCBS over three years?				48.5%		
	b) Transition to LTC?				14.4%		
Unique Users	SFY08	SFY09	SFY10	SFY11	SFY 2008/ 2011	SFY 2010/2011	
LTC		197	279	333	14.4%	3.8%	HCBS in 2010 to LTC in 2011
MRDD		1	1				
Waiver	2308	1767	1419	1120	48.5%	78.9%	
SPMI		10	12	12			
MedNeedy		4	7	8			
NotMedNeedy		88	84	71			
Total	2308	2067	1802	1544	66.9%	85.7%	

What happens to duals who are in LTC over time?						
Among unique users of LTC in 2008, how many are:						
	a)Medicaid eligible at all three years later?				44.0%	
	b) Medicaid eligible and in LTC				40.1%	
	c) Medicaid eligible but no longer in LTC?				274	3.9%
Unique Users Type	SFY08	SFY09	SFY10	SFY11	SFY 08/11	
LTC	6976	5116	3671	2794	40.1%	
MRDD		5	6	7		
Waiver		24	29	31	0.4%	
SPMI		17	26	26		
MedNeedy		134	87	64		
NotMedNeedy		245	182	146		
Total	6976	5541	4091	3068	44.0%	
Significant turnover in population over three years						
Most due to loss of eligibility, likely primarily due to death.						
Few return to community in one or another manner:						

56% of those in the LTC population in 2008 were no longer Medicaid eligible in 2011. Only 3.9% of those in the LTC population in 2008 remained eligible in 2011 and were no longer in the LTC group.

Where did the duals who are in LTC in 2011 come from?						
Of unique users in 2011:						
	a) how many were Medicaid eligible three years earlier?					57.1%
			two years earlier?			70.6%
			one year earlier?			86.9%
	b) how many were we serving in a prior year with HCBS services?					sfy10/sfy11
						3.9%
			from community not in HCBS			8.8%
	Unique Users SFY08	SFY09	SFY10	SFY11	08 vs 11	
LTC	2794	3757	5028	6779	41.2%	
MRDD	26	19	12			
Waiver	333	273	266			
SPMI	92	73	38			
MedNeedy	117	212	237			
NotMedNeedy	512	452	311			
Total	3874	4786	5892	6779	57.1%	
864	12.7%	of persons in LTC in 2011 had presence in community in the prior year.				
We know who most of the people are before they become LTC users.						
There are more people moving to LTC from other categories than from Waiver groups.						
Could point to effectiveness of waiver and/or need to better identify persons at risk						

86.7% of those in LTC in 2011 were Medicaid eligible 2011. Of the 6,779 person in LTC in 2012, 5028 were in LTC in 2010. Of the additional 1,751 who became LTC duals in 2011 864 or 49% were in other Medicaid population groups in 2010.

Question 6: **Can the State please provide a listing of providers that are not accepting new Rhody Health Options patients? (LOI-page 37- Section 3.6 Provider Network)**

Answer to question 6:

Rhody Health Options is a new program that the state is initiating. Therefore, Rhody Health Options networks do not currently exist. This is information the health plan would need to report to the state when describing its provider network. The procurement identifies that a robust network and access to care is required of bidders.

Question 7: **Please clarify the expectation. (LOI – page 88- Section 4.6.4 Technical Response C) (10)**

Answer to question 7:

Home based primary care, as implemented by the Department of Veterans Affairs, is described as a best practice in Section 3.19 of the LOI. Bidders are expected to use this best practice example to describe how they would create a network of primary care providers who would deliver home-based primary care to high need medically complex members. Additional materials regarding the VA program can be found in the procurement library.

Question 8: **Can the State please clarify its intentions about the Consumer Advisory Committee's composition and specific responsibilities? (LOI – page 85- Section 4.6.3 Experience and Understanding)**

Answer to question 8:

The state expects bidders to actively engage a representative group of consumers covered by this procurement in a meaningful way. This is best accomplished through a consumer advisory committee comprised of members that meets on a regular basis in order to inform program improvements. Bidders should outline their approach to the composition and responsibilities of this committee as part of the proposal submission.

Question 9: **Has the Rhode to Home program progressed to any of the populations contemplated for Phase II—namely, transitioning adults with disabilities from acute and long-term acute care facilities; adult patients with medical and behavioral health conditions from the Eleanor Slater Hospital; and children and youth in psychiatric hospitals and in-state and out-of-state Institutions for Mental Disease? (Model Contract- Section Attachment M)**

Answer to question 9:

As of the date of this response, Rhode to Home has not expanded to the populations outlined in Phase II of the Rhode to Home demonstration project. Rhode to Home continues to target nursing home residents who meet the Rhode to Home eligibility requirements.

Question 10: **There are migration savings calculated on page 194 of Attachment I. This calculation is based on total dollar savings assuming a shift in members. These migration savings are then applied to PMPM amounts on page 196. It seems as though the migration savings should affect the composite across rate categories, but not the PMPM amounts for each category. This seems to be inappropriately reducing the rates by about 6% on average. Please clarify. (Model Contract – Section Attachment I)**

Answer to question 10:

Each plan's composite rate experience across all rate cells will differ depending on the plan's distribution of enrollment across the rate cells. Therefore, the transition / migration savings are stated on a rate cell basis.

Critical to the success of Rhody Health Options is the ability for contracted health plans to transition clients from nursing homes to community settings with appropriate supports. In order to be successful, contracted health plans will be expected to target individuals who have been in the nursing home for more than ninety (90) days and are eligible for the Rhode to Home program. Contracted health plans will be expected to work collaboratively with EOHHS program staff in order to achieve the goals of the Rhode to Home program.

Question 11: **A program adjustment was made for Article 15, information about which commences on page 190 of Attachment I. Is this adjustment included in the trend assumptions? How was this adjustment developed? (Model Contract – Section Attachment I)**

Answer to question 11:

See table 3b, preceding the information on Article 15. In developing the composite trend, the unit cost component for inpatient and outpatient services were set at the estimated CMS market basket rates for the effective rate year.

Question 12: **A 1% savings adjustment was made for assumed Fraud & Abuse savings. What is the basis/support for this assumption? (Model Contract – Section Attachment I, p.195)**

Answer to question 12:

The basis for this assumption was current program savings in RIte Care and Rhody Health Partners. The capitation rates assume improved fraud, waste, and abuse detection efforts for managed care enrollees.

Question 13: **The ACA provides for temporary increases to PCP fee levels in 2013 and 2014, which would impact crossover payments. Has this been reflected in the RHO Data Book? (Model Contract – Section Attachment I)**

Answer to question 13:

This has not been reflected in the databook. PCP increases relative to ACA will be reimbursed outside the capitation rate. Selected bidders will be required to comply with all program requirements issued by EOHHS for PCP payment increase.

Question 14: **Is there any enrollee cost sharing that needs to be added in? (Model Contract – Section Attachment I)**

Answer to question 14:

Rhody Health Options enrollees will not have service level co-pays. However, some LTSS recipients contribute a share of their income towards the cost of their LTSS services. This payment is called the patient share. Patient shares are calculated by state eligibility technicians on an individual basis, and will be communicated to participating health plans. Providers will retain responsibility for collecting the patient share from the member. This pertains to both nursing home and home-based services.

Question 15: **Were there any service expansions during or since the base period, or any expanded services that Health Plans will be required to cover? (Model Contract – Section Attachment I)**

Answer to question 15:

There were no additions to the Medicaid fee-for-service benefit package during the base period.

Question 16: **Were there any changes in the eligibility provisions during or since the base period? (Model Contract – Section Attachment I)**

Answer to question 16:

No.

Question 17: **Enrollment:**

a. **Please clarify whether members of Rhody Health Partners who are newly identified as needing LTSS, will be transitioned to Rhody Health Options during Phase 1.**

b. **ID card distribution turnaround time: In Attachment J: Performance Goals, page 20 it states "Member ID Cards - % of identification cards distributed within 10 calendar days of Plan receipt of enrollment information. However, under section 2.05.02 Health Plan Enrollment Procedures for Rhody Health Options Eligibles, page 20, it states that "Members must be mailed notification of Rhody Health Options enrollment including effective date and how to access care within seven (7) calendar days after receiving notification from their State of their enrollment." Please clarify if it is 7 or 10 calendar days.**

c. **Effective date of coverage: Will RHO members become effective on the first day of the following month after receiving notification from the State (as listed on page 20 under section 2.05.02) or seven (7) calendar days after receiving notification from the State (as listed on page 19 under section 2.05.02)?**

d. **In Phase 1, when the Medicare benefit is not yet within the plan, does the MME population need to be assigned a PCP through the Managed Care Plan?**

Answer to question 17:

a) Yes
b) The intent is for identification cards to be sent within 7 days of notification of enrollment to the health plan. Article 2 of the Agreement and Attachment J will be updated to reflect this clarification.
c) RHO members will become effective on the first day of the following month after receiving notification from the State. Article 2 of the Agreement will be updated to reflect this clarification.
d) No

Question 18: **Care Management:**

a. LOI, page 46 states: " Bidder conducts Telephonic Initial Health Screen on all new member not currently receiving LTSS within 45 days of enrollment and every 180 days thereafter" whereas, the Model Contract, attachment L, page 220 states the "Initial Telephonic Screen……. occurs 45 days of enrollment and every 90 days thereafter" Please clarify correct timeframe.

b. Comprehensive Functional Assessments LOI, page 47 states: "An in-person reassessment is conducted every 90 days if LTSS and 180 days if institution, whereas, the Model Contract, attachment L, page 221, says the in-person reassessment is conducted every 60 days if LTSS and 90 days if institution. Please clarify correct timeframe.

c. Post Hospitalization LOI, page 47 states: "a home assessment must occur within 5 days, whereas, page 37 states a person must receive an in-person visit to their residence with 24 hours of being discharged from the hospital or nursing facility. Please clarify correct timeframe.

d. The LOI and Model Contract appropriately require in depth assessment for individuals that trigger for potential help through an initial screen. We believe that in certain circumstances an individual may trigger for a more comprehensive screen based primarily on social issues, rather than clinical issues. In those situations where the individual's needs appear to be more socially focused, may the plan use a trained para-professional to conduct the face-to-face assessment?

e. Please clarify how care management will work during Phase 1. Are plans responsible for providing care management plan related only to the LTSS for Rhody Health Options members, or are plans responsible for developing a care management plan for all services, including Medicare services?

f. Given in Phase 1 plans are not managing the Medicare benefit, will the state require hospitals to notify the plan of an MME hospital admission, in order for the plan to effectively provide the in-home visit after discharge as required in the LOI.

g. We are supportive of the intent of conflict-free case management but are not sure how it works with ongoing efforts to streamline processes for members, providers and plans. Please clarify the application of conflict free case management in these situations:

i. May a plan care manager provide service authorizations or must that go through a plan's utilization management department?

ii. Is it possible for a plan to use a provider such as a Visiting Nurse Association or Primary Care Medical Home (PCMH) to provide an assessment of an individual?

Answer to question 18:

a) The intent is for the telephonic health screen to be conducted every 180 days after the first initial screen is conducted. Article 2 of the Agreement and Attachment L will be updated to reflect this clarification.

b) The intent is for the comprehensive in-person comprehensive assessment is conducted every ninety (90) days for all LTSS clients – those residing at home and those residing in a nursing home. Article 2 of the Agreement and Attachment L will be updated to reflect this clarification.

c) The intent is for a home assessment to occur within twenty-four (24) hours of inpatient discharge. Article 2 of the Agreement will be updated to reflect this clarification.

d) In those situations where the individuals' needs appear to be more social in nature, EOHHS will consider allowing a para-professional to conduct the face-to-face comprehensive needs assessment. Para-professionals in this role must be supervised by a licensed clinician, and also must receive robust training. EOHHS will review all relevant policies and procedures before making a final determination.

e) Health Plans should take a person-centered approach to developing the Plan of Care. This Plan of Care would include all services the member may need, regardless of payer. For those services not covered by the Health Plan, the care manager would assist the member in navigating the appropriate delivery system in order to access the services.

f) The state cannot require hospitals to notify Medicaid health plans of a Medicare admission. For clients who are receiving LTSS at home or in nursing homes, the Medicaid health plans will be expected to establish communication mechanisms with network providers to inform the health plan of members who are admitted to the hospital.

g)

i. The plan care manager may provide service authorizations, as long as the plan is in compliance with Utilization Review regulations, as they pertain to Medicaid managed care.

ii. Yes.

Question 19: **Pharmacy Services:**

a. Will Medicaid reimburse any medications, such as over the counter medications, which fall outside of the Part D benefit in Phase 2?

Answer to question 19:

Health Plans will be responsible for Medicaid-covered pharmacy benefits, including over-the-counter medication. These historical pharmacy costs are contained in the capitation rate.

Question 20: **Rate Methodology:**

a. Do the rates for Phase 1 include payment of a member's Medicare co-pay?

b. Does the Medical Portion of the rate in Phase 1 include care management and/or coordination or is that included as part of the administrative rate?

c. Will the nursing homes and other applicable providers continue to receive the applied income payment directly from the member or their assigned designee? If the plans are responsible, how will the plans obtain the necessary information in order to deduct the member share from our claims payments?

d. Please specify the services covered by FFS Medicaid during Phase 1, exclusive of BHDDH.

Answer to question 20:

a) The rates for Phase I contain any crossover claims payments, but do not contain patient share obligations. Rates presented are net of patient share.
b) All care management costs are in the administrative portion of the capitation rate
c) Yes. EOHHS will send this information to participating health plans, so that payments to providers can be adjudicated net of patient share.
d) These services are listed in Attachment B of Appendix C (the model contract) and include dental services, HIV/AIDS non-medical case management, and court-ordered mental health and substance abuse services.

Question 21: **Dental**

a. Please clarify the extent of the dental benefit to be administered in Phase II by the health plans. Does it only include preventive oral health (e.g., cleanings and exams) or will the plans be responsible for a more comprehensive benefit (e.g., preventive and restorative – fillings, root canals, extractions, crowns).

Answer to question 21:

The state is considering an approach to providing an oral health benefit for Medicaid-only and MME members through managed care, and is seeking recommendations on how to design a benefit package, ranging from preventive services to a more comprehensive benefit. Bidders' response should include these recommendations, and emphasize opportunities for providing oral health care in lieu of costlier services (e.g. emergency room care).

Question 22: **Coordination between Medicare and Medicaid**

a. Will there be any requirements pertaining to coordination of benefits between Medicaid and Medicare services during phase 1 of the Integrated Care Initiative

b. During Phase 2, will Bidder be required to post MME enrollment/disenrollment transactions to CMS systems?

Answer to question 22:

a. Health Plans should take a person-centered approach to developing the Plan of Care. This Plan of Care would include all services the member may need, regardless of payer. For those services not covered by the Health Plan, the care manager would assist the member in navigating the appropriate delivery system in order to access the services. In addition, health plans will be expected to leverage Medicare as the primary payer for members as appropriate.

b. The Phase II requirements will be available in the summer of 2013.

Question 23: **Could you please provide detailed claims utilization (i.e. units, units/1,000, and patients) by category of service? (Appendix C - 3 of 3- Section Attachment I - Rate-Setting Process- p. 192 & 193 Table 5a &b)**

Answer to question 23: See below.

Rhody Health Options (RHO) - Response to Question #23

Rate Setting

For 9/1/13 - 6/30/14

Base Period: SFY 2011 (7/1/2010 - 6/30/2011)

Rhody Health Options - MME (Dual Eligibles)

	LTC		MRDD		Waiver		SPMI		Community		LTSS	
Average Members	5,481		2,237		2,831		2,551		13,409		905	
	PMPM	**Util/1000**	**PMPM**	**Util/1000**	**PMPM**	**Util/1000**	**PMPM**	**Util/1000**	**PMPM**	**Util/1000**	**PMPM**	**Util/1000**
Inpatient	$ 5.03	2.9	$ 3.73	3.2	$ 3.82	5.0	$ 26.14	28.9	$ 8.70	7.9	$ 1,618.06	1,483.6
Outpatient	$ 363.18	302.8	$ 3.64	183.2	$ 25.22	1,582.2	$ 4.32	199.7	$ 4.64	171.9	$ 622.67	11,592.1
Professional	$ 5.63	480.5	$ 54.03	4,378.6	$ 122.28	5,491.0	$ 62.70	2,957.2	$ 16.81	1,498.1	$ 514.50	59,794.5
Nursing Home	$ 3,962.01	1,430.4	$ 5.35	17.4	$ 56.36	174.5	$ 4.64	12.5	$ 21.31	47.7	$ 1,177.90	522.5
Rx	$ 0.80	5,809.3	$ 5.15	13,414.0	$ 2.33	10,444.5	$ 7.06	9,772.1	$ 4.69	5,740.7	$ 405.95	107,434.0
Waiver	$ 24.35	772.0	$ 2.05	29.1	$ 1,218.76	40,158.5	$ 0.05	8.2	$ 0.66	16.7	$ 758.02	29,709.2
Crossover												
Crossover - IP	$ 12.41	303.0	$ -	-	$ 21.26	543.4	$ 13.95	320.8	$ 9.19	229.7	$ -	-
Crossover - OP	$ 5.09	1,025.9	$ 21.72	17,229.3	$ 15.38	3,699.9	$ 8.15	3,498.7	$ 9.37	2,864.0	$ -	-
Crossover - Prof	$ 4.96	23,544.5	$ -	-	$ 20.30	29,677.7	$ 10.43	21,798.5	$ 15.19	16,031.8	$ -	-
Total	$ 4,383.46	33,671	$ 95.67	35,255	$ 1,485.71	91,777	$ 137.44	38,597	$ 90.57	26,609	$ 5,097.11	210,536

Note: Utilization/1000 refers to admissions/1000 for Inpatient

Question 24: **Is behavioral health expenditures included in any other categories of service other than Behavioral Health (BH) - Outpatient and Behavioral Health (BH) - Professional? (Appendix C - 3 of 3- Section- Attachment I - Rate-Setting Process- p. 192 & 193 Table 5a &b)**

Answer to question 24:

Behavioral Inpatient was included in the Inpatient category for the MME rate cells, while it was stated separately for the MA Only rate cell, as shown in the tables. Behavioral inpatient expenses for SFY 2011 for all MME rate cells except SPMI were negligible. For SFY 2011, the Behavioral Inpatient expense for SPMI was $24.21 PMPM out of the stated Total Inpatient expense of $26.14 PMPM

Question 25: **What HCPCS, CPT and/or revenue codes are included in the behavioral health lines? (Appendix C - 3 of 3- Section Attachment I - Rate-Setting Process- p. 194 & 195 Table 6a &b)**

Answer to question 25:

Table 6a and 6b in Attachment I depict program adjustments and assumptions related to program initiatives, and not include any "behavioral health lines" as indicated in the question. However, all Medicaid-covered behavioral health services included in the rate setting process are listed in Attachment A - In Plan Benefits.

Question 26: **Section 2.5 of the Bidder Certification Cover Form requires that all information is public except for that which is exempt, such as trade secrets and other confidential information. If our response will be made public, will we be given an opportunity to provide a redacted version or mark certain sections of our response as "proprietary?" (Bidder Certification Cover Form- Section 1- page 1)**

Answer to question 26:

No, you will not have an opportunity to redact certain sections; however, if you feel that any thing is a clear trade secret and proprietary, please indicate that in your proposal submission and the state will review.

Question 27: **This Section states that the LOI and any subsequent award(s) are governed by the State's General Conditions of Purchase, and the Section sites the location of the governing Regulations. These regulations require that all subcontracts require express consent of the State, but the governing agency at issue is the Office of Purchases. Does the General Conditions of Purchase #3. prevail and require**

approval of all subcontracts by the Office of Purchase? (LOI-Section Chapter 1 Section 1.1- p.4)

Answer to question 27: Yes.

Question 28: **Is it the State's intent for behavioral health services currently provided by BHDDH to be carved out for SPMI members? If so, please list specific services (such as HCPCS, CPT and/or revenue codes) that will be carved out. Does the State intend to have Health Plans cover all other services for SPMI members including LTSS? (LOI-Section 2.5 Integrated Care Initiative-p. 22-23)**

Answer to question 28:

Behavioral health services currently provided by BHDDH will be carved out for SPMI members for Phase I of the Integrated Care Initiative. During Phase II, the State intends that those specialized services funded and managed by BHDDH for individuals with SPMI and developmental disabilities may become in-plan services as designed by new State requirements.

Question 29: **Item (8) of this request references requirements in section 2.15 of the Model Contract which is "Grievance & Appeals. Should item (8) be referencing section 2.16 Payments to and From Plans? (LOI- Section 4.6.4.J- p.90)**

Answer to question 29:

The correct reference should be section 2.16 Payments to and From Plans within the Model Contract.

Question 30: **Please provide additional information about the timeline, including a date for expected contract award and expected date for readiness review? (LOI-Section 4.9 & 4.10-p.94)**

Answer to question 30:

The current timeline aims for the awarding of contracts to occur in early May 2013 with an intense onsite readiness review to be conducted during the months of May and June 2013 to follow.

Question 31: **Is it the State's intent for LTSS services to be carved out for members with developmental disabilities? If so, please list specific services (such as HCPCS, CPT and/or revenue codes) that will be carved out. Does the State intend to have**

Health Plans cover all other services for members with developmental disabilities? (LOI-Pathway #2-Section2.5 Integrated Care Initiative- p.22-23)

Answer to question 31:

LTSS services for members with developmental disabilities will be carved out for Phase I of the Integrated Care Initiative. During Phase II, the State intends that those specialized services funded and managed by BHDDH for individuals with SPMI and developmental disabilities may become in-plan services as designed by new State requirements.
Services for DD clients fall into three broad categories; day supports, in-home supports and other supports. These categories are listed below, and the specific services bulleted underneath the appropriate category.

- Day supports
  - Vocational services and vocational assessment
  - Job development and job supports
  - Center-based vocation services
  - Sheltered workshop
  - Adult development
  - Specialized services
  - Additional supports like sports and recreation, leisure activities, community classes and community trips
- In home supports
  - Respite
  - Personal care
  - Independent living skills
  - Community connections
- Other support
  - Home modifications
  - Adaptive equipment
  - Residential supports (group homes, apartments, and shared living arrangements)

Question 32: **The State is requiring the Bidder to accept the Risk Sharing arrangement in Attachment K. Will the State consider alternate risk sharing arrangements or other common approaches such as the ACA MLR targets in lieu of what is set forth in Attachment K? May the Bidder propose an alternate risk sharing arrangement in lieu of Attachment K and not be disqualified or be deemed nonresponsive? (Model Contract - Attachment K-Section Attachment K –p. 206-211)**

Answer to question 32:

Bidders must be prepared to accept the risk-sharing arrangements outline in Attachment K. Bidders may submit alternative risk sharing arrangements in its bid submission for EOHHS to consider.

Question 33: **In same paragraph as effective date of membership on page 19, notification must be mailed to the members within 10 calendar days after receiving notification. On page 20, also in the same paragraph as the different effective date comment, it states notification must be mailed to members within 7 calendar days after receiving notification. Please confirm if the requirement is 7 calendar days or 10 calendar days. (Model Contract 1- Section 2.05.02–p.19-20)**

Answer to question 33:

The requirement is 7 calendar days. Article 2 of the Agreement will be updated to reflect this clarification.

Question 34: **OHIC Affordability standards (Procurement Library) are specifically directed to RI Commercial Health Plans. Does the state intend for bidders to meet all of the specific commercial requirements as outlined in the attachment? (Model Contract and LOI and Procurement Library-Section 2.10.11- p. Model Contract-p. 47 and LOI page 30-31)**

Answer to question 34:

Yes. It is EOHHS' intent for bidders to meet all of the OHIC Affordability Standards.

Question 35: **The State is requiring Bidder to contract with "essential community providers: in Appendix B unless Bidder demonstrates a valid reason for not including them. Please explain the state's intent regarding the last statement in Appendix B (Essential Community Providers) "All other providers for Habilitation are Licensed Home care agencies that provide assistance with Personal care and Homemaking and/or Skilled Nursing", is this a statement or a requirement? (Model Contract-Appendix B and LOI- Section 2.09.01 - Contract 2.09.01; Appendix B not numbered also see requirement p. 38 LOI)**

Answer to question 35:

Bidders should disregard this sentence – it was included in error.

Question 36: **The health insurer tax under PPACA becomes effective 1/1/14. Will the state include this tax as part of the rate build for all impacted bidders?**

Answer to question 36:

This is a fixed price bid. The rates the state will pay to participating health plans are contained in Attachment G of Appendix C (the model contract).

Question 37: **In the Data Book the state adjusts for Generics First in Phase I. Is the state expecting the health plans to manage Part D benefits in Phase I? Has the state seeking approval from CMS to allow Generics First? (Pharmacy)**

Answer to question 37:

In Phase I, Contracted Health Plans will not be managing the Part D benefit for MMEs. Contracted Health Plans will be managing the Medicaid pharmacy benefit for Medicaid-only clients. Successful bidders will need to conform with the EOHHS Generic First program policies. Federal authority already exists for the Generic First program for Medicaid-only members.

Question 38: **This section discusses how the consumer will have a choice with regard to which model they will enroll in: CCCCP, Health Plan, or PACE. Yet it then indicates the capacity to enroll new members is "particularly limited" with PACE, and "somewhat limited" with the CCCCP model. The Integrated Care Initiative estimates that 5,000 individuals will enroll in CCCCP. How will the state ensure consumer choice and access if more than 5,000 individuals choose the CCCCP model and / or opt out of the Health Plan model? Will there be caps on the number of individuals in the CCCCP model? (Section 2.6 Enrollment Approach)**

Answer to question 38:

The State does not envision a cap on the number of individuals in the Connect Care Choice – Community Partners (CCC*CP*) model. Enrollment in this model is driven by members who receive their primary care in a Connect Care Choice (CCC) practice. Capacity for the CCCCP model is driven by provider and member capacity within the 17 CCC practice sites. The state is ensuring choice through enrollment in a participating MCO or in a participating CCC practice as appropriate. The 5,000 enrollment target is based on the current CCC practice site enrollment and an estimate of the likely enrollment from members who are MMEs. Appendix A of the CCC*CP* LOI provides detail on the target populations for this program. For clients interested in the PACE program, information will be provided upon request.

Question 39: **The LOI expects the Health Plan applications to describe "the specific LTSS network (i.e. institutional and HCBS providers) including a geographic access analysis of the LTSS network to determine the accessibility of services (p. 87)." Will Health Plans be able to add additional providers once the LOI is submitted? This is important because Appendix B may not be a comprehensive or most up-to-date list of Long Term Care Providers. For example, Arbor Hill Assisted Living, a Medicaid-certified, licensed assisted living residence is not included on the list. In addition, availability and access to services can change frequently. (Section 4.6.3)**

Answer to question 39:

Appendix B was not intended to be an exhaustive list of all LTSS providers. It is included in the LOI for informational purposes. The source data for Appendix B was the RI

Department of Health Licensure Division. As the vendor indicates, updates are made on a routine basis, and Appendix B only captured information at the time the LOI was written.

Bidders cannot adjust their submission after the due date to reflect new network providers. However, successful bidders whom are awarded contracts will be expected to update their network of providers on a routine basis.

Question 40: **This section notes that "the State has implemented a new reimbursement methodology that takes into account the severity of need as well as the facilities costs. The Bidder may implement the current system or may propose their own system that reflects the State's quality indicators. The Procurement Library contains information of the State's current approach for reimbursing nursing homes." The Procurement Library does not include the updated approach for reimbursing nursing homes as established by RIGL Section 40-8-19 and distributed to nursing homes on September 27th 2012. In addition, the Section indicates that the Health Plan may propose their own system that "reflects the State's quality indicators." The quality incentive measures outlined in Attachment J relate more to the performance of the Health Plan rather than the quality of care in a nursing home. At this time there are no nursing home-related quality indicators. Is there a timeframe for the development of quality indicators for nursing homes that can be incorporated into any proposed payment methodology? (Section 3.15 Payment To and From Health Plans)**

Answer to question 40:

The September 27, 2012 correspondence does not alter the methodology that was described in the documents in the procurement library. The September correspondence was the application of the methodology to arrive at rates for individual nursing home providers. The document in the procurement library dated May 10, 2012 and titled "EOHHS/Medicaid Nursing Home Reimbursement Methodology – Overview" outlines the methodology used to arrive at the rates issued in September 2012.

The preliminary nursing home quality measures for Phase I are included in Appendix C (Model Contract), Attachment N, pages 250-251. EOHHS is willing to engage in collaborative efforts with selected bidders to create additional nursing home quality measures.

Question 41: **Attachments G and H of the Model Contract**
These attachments describe the calculation of the capitation rates for the different beneficiaries, described as "Premium Rating Groups." Given the importance of ensuring that capitation rates are adequate to reflect the risk that Health Plans are being asked to assume, and the attendant implications for provider reimbursement, LeadingAge RI has the following questions:

a. **On p. 192, the section of the table "Care Management Services – Adjustment Factors", the line item for "Institutional – Nursing Home" includes a footnote "(a)", but there does not appear to be an associated reference. Any further information would be appreciated as this line item plays a significant**

role in the calculation of the Care Management Savings that is used to develop the capitation rates.

b. On p. 194, it is not clear how the Target Rates for the Transition / Migration Interventions are calculated to arrive at the final Target (Managed Care) percentage rates. In addition, The Target Rates assume a transition rate of 6% for individuals transitioning out of nursing homes and into the community, significantly higher than the current rate of .05%. Please clarify what this estimate of 6% is based upon, as it again plays a significant role in the calculation of the capitation rates. What is the process for adjusting capitation rates should certain Target Rates not be achieved?

c. These attachments refer to a 2% Premium Tax, but it is not clear how this is applied. Also, how does the current nursing home provider tax operate in this environment, will it continue to be a pass-through to nursing homes?

Answer to question 41:

a) This footnote reference was included in error – this was a typo. Please disregard.
b) The six percent (6%) estimate of individuals transitioning to nursing homes was calculated using historical program experience from Rhode Island, as well as the experience in other states that have transitioned from a fee-for-service delivery system to a capitated model for Medicaid managed LTSS. Capitation rates are adjusted annually and will incorporate experience from the most recent complete base period, as well as adjustments for program initiatives. Capitation rates will be recalculated for the period July 1, 2014 through June 30, 2015.

   The premium rating group labeled LTC in Attachment I was developed using historical utilization data for beneficiaries with ninety (90) or more Medicaid paid days in a nursing home. The development of the LTC and Waiver premium rates include a "transitional" component. This means that when an LTC member transitions to the community with supports, the contracted health plan will continue to receive the LTC premium rate for a period of ninety (90) days. Conversely, when a waiver member transitions to a nursing home, the contracted health plan will continue to receive the waiver premium rate for a period of (90) days.

c) The premium tax referenced in Attachment I of Appendix C is an assessment on managed care organizations, (R.I. Gen. Laws § 44-17-1) and not on individual providers. The nursing home tax assessment currently in effect was included in the underlying experience used in the development of the capitation rates. Nursing home providers should negotiate with the selected health plans to negotiate an appropriate reimbursement rate. The selected bidders' nursing home reimbursement methodology is subject to EOHHS review and approval.

Question 42:

The State's response to a question asked 10/22/12 and answered 11/14/12 stated "a fee schedule can be made available upon request." Given the short time between the procurement and anticipated "go-live" date would the State provide the fee

schedule for LTSS? (Stakeholder questions asked10/22/12 and state response to the question on 11/14/12)

Answer to question 42:

Current Medicaid fee-schedules will be made available to selected bidders after the provisional aware letter is issued in early May.